



Reporting Monthly Participation in Community Engagement Activities Granite Advantage Health Care Program

Use this form to report your monthly participation in one or more of the community engagement activities listed below. **DETAILED INSTRUCTIONS ARE ENCLOSED.** Please print all information in the spaces provided.

Name: _____

Last _____ First _____

Medicaid ID#: _____

By filling in the circle below to select activities and signing this form I attest, under penalty of unsworn falsification pursuant to RSA 641:3, that I participated in the qualifying community engagement activitie(s) indicated below for the hours stated and that all of the information that I have provided to the department is true to the best of my knowledge and belief.

Beneficiary Signature _____ Date _____

FOR THE PARTICIPATION MONTH OF (MM/YYYY): _____

Community Engagement Activities	Total Hours Per Month
<input type="radio"/> Job Search and Job Readiness Enter total hours here >	_____
Please list the job search/job readiness activities that you participated in during the month and the number of hours for each activity. Enter the total number of hours for the month above.	
<input type="radio"/> Community Service, Volunteering, or Public Service Enter total hours here >	_____
Please list each place where you volunteered or provided community or public service during the month and the contact person, contact information (phone or email), date(s) and number of hours that you performed for each place. Enter the total number of hours for the month above.	

Community Engagement Activities	Total Hours Per Month
<input type="radio"/> Caregiver Services For a Non-Dependent Relative Or Other Person With a Disabling Condition Enter hours here >	<input type="text"/>
<p>Please provide the name and contact information (phone or email) for the non-dependent relative or other person with a disabling condition for whom you provided caregiver services. Please describe the caregiver services that you provided and indicate the number of hours that these services were provided during the month. Enter the total number of hours for the month above.</p>	
<input type="radio"/> Participation in Outpatient Substance Use Disorder Services Enter hours here >	<input type="text"/>
<p>Please identify the agency or organization where you are receiving services. Enter the total number of hours for the month above. The hours recorded may not exceed 40 hours in a monthly period.</p>	
<input type="radio"/> Additional Work Hours Enter hours here >	<input type="text"/>
<p>If you worked more hours this month than you were automatically credited as shown in your status letter, enter the additional hours above. Please list the Employer's name, contact person, contact information (phone or email), date(s) and additional number of hours that you worked for each place you were employed during the month.</p>	
<input type="radio"/> Additional Self-Employment Hours Enter hours here >	<input type="text"/>
<p>If you worked more hours this month than you were automatically credited as shown in your status letter, enter the additional Self-Employment hours above. Please provide a description of the additional self-employment hours during the month.</p>	

Instructions for Completing the Form

1. Enter your identifying information and sign and date the top section of the form.
2. Enter the month you are reporting activities for as a two-digit month and a four-digit year.
3. In the Community Engagement Activities section, completely fill in the circle to the left of the activity that you are reporting. If you have any questions regarding activities, a description can be found below.
4. Enter the total number of hours for the month in the far right column of the row which applies to the community engagement activity that you are reporting.
5. The beneficiary **MUST** return this form to the Department of Health and Human Services either by mail at the address above, by fax to (603) 271-5623 or by submitting the form through your NH EASY account, or bringing the form to a local district office. You can call 1-844-275-3447 (1-844-ASK-DHHS) if you have any questions.

Descriptions of Community Engagement Activities

Job Search and Job Readiness	This activity includes, but is not limited to, participation in job search or job training activities offered through the Department of Employment Security or through other job search or job readiness assistance program such as Workforce Innovation and Opportunity Act (WIOA) or Work Ready New Hampshire. Time spent in any assessment, training, enrollment or case management activity that is necessary for participation in this activity is credited toward job search and job readiness assistance hours. Attestation must include the type and duration of the activity.
Community Service or Public Service (Volunteer)	This activity requires attestation of where and when the community or public service was performed and the number of hours worked. The attestation must include contact information for the community service or public service agency.
Caregiver Services For a Non-Dependent Relative or Other Person With a Disabling Condition	This activity is for caregiving services provided to a non-dependent relative or other person with a disabling medical, mental health or developmental condition. It requires attestation by the beneficiary as to the services provided including the name of the non-dependent relative or other person with a disabling condition and the number of hours of caregiving services provided.
Participation in Outpatient Substance Use Disorder Services	This activity is for participation in ASAM Level 1 outpatient substance use disorder services, including medication assisted treatment, and recovery supports. It requires self-attestation of the number of hours that the beneficiary participated in the services up to 40 hours per month.
Additional Work Hours	A temporary increase in monthly employment hours for seasonal or other work that is above the beneficiary's average monthly employment hours may be reported as an activity. The reporting of additional employment hours as an activity under this section shall be limited to 2 consecutive months.
Additional Self-Employment Hours	This activity is for beneficiaries who are self-employed and work more hours than calculated by the department's eligibility system(s), the beneficiary shall report the additional hours worked.

Beneficiary Authorization for Licensed Medical Professional to Release Protected Health Information
Granite Advantage Health Care Program

This form authorizes a licensed medical professional to release to the Department of Health and Human Services (Department) a beneficiary's protected health information (PHI) related to the licensed medical professional's certification of the beneficiary as medically frail. This form should be completed by the beneficiary and given to the licensed medical professional who is completing the Licensed Medical Professional Certification of Medical Frailty Form 331.

The beneficiary **MUST** return a copy of this form along with a copy of the Licensed Medical Professional Certification of Medical Frailty Form 331 to the Department. The forms may be sent to the Department by mail at the address above, by fax to 603-271-5623, by submitting forms to NH EASY, or bringing the forms to a local district office. The forms can be submitted through NH EASY by logging on to nheasy.nh.gov, accessing the Granite Advantage Community Engagement page and uploading the forms. A beneficiary may upload the forms to NH EASY or bring the forms to their local district office only if the licensed medical professional has certified that the beneficiary is medically frail.

Part I. Beneficiary Information (please print)

Last Name:	First Name, Middle Initial:	Date of Birth MM/DD/YYYY
Residential Street Address (if homeless write N/A):	City, State, Zip Code:	Phone #: ()

Part II. Purpose of the Disclosure The purpose of the disclosure of PHI pursuant to this release is to verify the licensed medical professional certification that the beneficiary is medically frail and that the beneficiary is accordingly exempt from the Granite Advantage Health Care Program community engagement requirements. I understand that if I do not authorize the release of this information, I will not be able to demonstrate that I qualify for an exemption with the necessary completion of the Licensed Medical Professional Certification of Medical Frailty Form.

Please check all that apply below:

- I hereby authorize the following licensed medical professional to disclose my protected health information for the purposes described above:

Name of Medical Professional: _____
Organization: _____ Telephone #: () -- _____
Address: _____

- In addition, I hereby authorize the following specific disclosures (Place your initials on the line by those statements which apply)

_____ I specifically authorize the release of my mental health treatment records.
_____ I specifically authorize the release of my HIV and AIDS results and/or treatment.

I specifically authorize the release of my alcohol and/or drug abuse treatment records in accordance with 42 CFR Part 2.

Other (specify): _____.

- I give authorization for my protected health information to be released to the following individual or organization:

Name: Granite Advantage Health Care Program Manager

Organization: Department of Health and Human Services

Address: DHHS, Granite Advantage Health Care Program, P.O. Box 3778, Concord, NH 03302-3778 or Fax# 603-271-5623

- I understand this authorization may be revoked by notifying the Department of Health and Human Services in writing to the address above.
- This authorization will expire one year from the date it is signed.

Signature of Beneficiary or Duly Authorized Legal Representative

Date

If you have any questions regarding this form, please call the Department's Medicaid Customer Services number at 1-844-275-3447 (1-844-ASK-DHHS).



Reporting Education Participation for Community Engagement Granite Advantage Health Care Program

Use this form to report your participation in one or more of the ongoing education community engagement activities listed below. **DETAILED INSTRUCTIONS ARE ENCLOSED.** Please print all information in the spaces provided and attach the required documentation to the form.

Name: _____

Last _____ First _____

Medicaid ID#: _____

By filling in the circle below to select activities and signing this form I attest, under penalty of unsworn falsification pursuant to RSA 641:3, that I participated in the qualifying community engagement activities indicated below for the hours stated and that all of the information that I have provided to the department is true to the best of my knowledge and belief.

Beneficiary Signature _____ Date _____

Community Engagement Activities	Total Hours Per Month
<input type="radio"/> Job Skills Training Related to Employment Enter hours here >	_____
The name of school or agency: _____	
The training start date (MM YYYY): _____	
The training end date (MM YYYY): _____	
<p><u>Attach documentation of your enrollment</u> which includes the duration and number of hours in the training program. Enter the total number of hours to be credited each month for the duration of your participation in the activity.</p>	

Community Engagement Activities		Credit Hours
<input type="radio"/>	Enrollment at an Accredited Community College, College or University	Enter Credits here > <input type="text"/>
The name of the college or university: <input type="text"/>		
The semester start date (MM YYYY): <input type="text"/>		
The semester end date (MM YYYY): <input type="text"/>		
Attach a copy of your class schedule which indicates the number of credit hours assigned for the enrolled classes. Enter the total number of credit hours.		

Community Engagement Activities	
<input type="radio"/>	Vocational Educational Training
The name of the institution: <input type="text"/>	
The training start date (MM YYYY): <input type="text"/>	
The training end date (MM YYYY): <input type="text"/>	
Attach documentation of your enrollment in the training program. Community engagement hours will be credited at 100 hours per month for the duration of your participation in the training program or activity.	
<input type="radio"/>	Education Directly Related to Employment (For a Beneficiary Who Has Not Received a High School Diploma or GED)
The name of the program or activity: <input type="text"/>	
The program or activity start date (MM YYYY): <input type="text"/>	
The program or activity end date (MM YYYY): <input type="text"/>	
Attach documentation of your enrollment in the program or activity. Community engagement hours will be credited at 100 hours per month for the duration of your participation in the program or activity.	
<input type="radio"/>	High School or Equivalent
The name of the high school or program: <input type="text"/>	
The high school or program start date (MM YYYY): <input type="text"/>	
The high school or program end date (MM YYYY): <input type="text"/>	
Attach documentation of your enrollment in the high school or program. Community engagement hours will be credited at 100 hours per month for the duration of your participation in high school or an equivalency program.	

Instructions for Completing the Form

1. Enter your identifying information and sign and date the top section of the form on the first page.
2. In the Community Engagement Activities section, completely fill in the circle to the left of the activity that you are reporting. If you have any questions regarding activities, a description can be found below.
3. Enter the total number of hours to be credited each month for the duration of your participation in the activity in the far-right column of the row which applies to the community engagement activity that you are reporting.
4. Attach the necessary documentation to the form.
5. The beneficiary **MUST** return this form to the Department of Health and Human Services either by mail at the address above, by fax to (603) 271-5623 or by submitting the form through your NH EASY account, or bringing the form to a local district office. You can call 1-844-275-3447 (1-844-ASK-DHHS) if you have any questions.

Descriptions of Community Engagement Activities

Job Skills Training Related to Employment	This activity requires documentation of enrollment in a job skills training program that includes the duration of the program and the number of hours that the beneficiary is participating in the activity.
Enrollment at an Accredited Community College, College or University	This activity requires enrollment at an accredited community college, college or university that is counted on a credit hour basis. Documentation of enrollment must include a copy of the beneficiary's class schedule, the number of credit hours assigned for the enrolled class(es) and the semester begin and end date. The number of community engagement hours that are credited toward the community engagement requirement each month is determined by multiplying the number of credit hours assigned for the enrolled class(es) by 4.33, and rounded up to the nearest quarter of an hour. For example, if you receive 15 credit hours per semester, your hours calculation would be the following: 15 credit hours x 4.33 = 64.95 hours. This will be rounded to 65 hours.
Vocational Educational Training	This activity requires documentation of enrollment in a vocational education training program that includes the duration of the activity. Community engagement hours are credited at 100 hours per month for the duration of the beneficiary's participation in the activity not to exceed 12 months.
Education Directly Related to Employment (Beneficiary Has Not Received a High School Diploma or GED)	This activity is for participation in education directly related to employment in the case of a beneficiary who has not received a high school diploma or certificate of high school equivalency. The activity requires documentation of enrollment that includes the duration of the activity. Community engagement hours are credited at 100 hours per month for the duration of the beneficiary's participation in the activity.
High School or Equivalent	This activity requires documentation of enrollment that includes the duration of the activity. Community engagement hours are credited at 100 hours per month for the duration of the beneficiary's participation in the activity.



Exemption Request Form Granite Advantage Health Care Program

Use this form to request an exemption from the Granite Advantage Community Engagement requirements. **DETAILED INSTRUCTIONS ARE ENCLOSED.** If a licensed medical professional must certify the exemption, ask them to complete the Section III.

Name:	
Last _____	First _____
Medicaid ID#: _____	

Section I. Self-attested exemptions and exemptions requiring beneficiary ACTION		
<input type="radio"/>	Participation in State Certified Drug Court Program	Attach a copy of the legal documentation
<input type="radio"/>	Parent/Caretaker of Dependent Child Under 6	Enter the child's DOB in the box at the bottom of the page
<input type="radio"/>	Pregnant or Within 60 Days Post-partum	Due Date: _____

By filling in the circle for an exemption in Section I or II below and signing this form, I attest under penalty of unsworn falsification pursuant to RSA 641:3 that the information provided to the department in support of this request is true to the best of my knowledge and belief.

Beneficiary Signature _____ Date _____

Section II. Exemptions requiring CERTIFICATION BY A LICENSED MEDICAL PROFESSIONAL		
<input type="radio"/>	Disability	Licensed Medical Professional
<input type="radio"/>	Caretaker Residing With Immediate Family Member with Disability	Licensed Medical Professional
<input type="radio"/>	Illness, Incapacity or Treatment Including Inpatient or Residential Outpatient Treatment	Licensed Medical Professional
<input type="radio"/>	Inpatient Hospitalization	Licensed Medical Professional
<input type="radio"/>	Caretaker Residing With Immediate Family Member Who Experiences Hospitalization or Serious Illness	Licensed Medical Professional
<input type="radio"/>	Parent/Caretaker of Developmentally Disabled Child	Licensed Medical Professional
<input type="radio"/>	Parent/Caretaker of Family Member Requiring Care	Licensed Medical Professional

For the Inpatient Hospitalization exemption, enter the hospital admitted date below:

Admitted Date: _____

For any Parent or Caretaker exemption, enter the information for the person being cared for below:

Full Name: _____
Last First

Date of Birth (MMDDYYYY): _____

Section III. Licensed Medical Professional Section

As a licensed medical professional caring for this beneficiary, I hereby certify (based on the description of the exemptions provided in the instructions to this form) that the beneficiary meets the qualifications for the exemption(s) requested in Section II.

This certification is valid through (may not exceed one year): _____

Provider Name (Please Print):	NPI #: _____
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Date:	Contact #: ()
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Provider Signature: _____

Instructions For Completing the Form

Beneficiary Instructions:

1. Complete your beneficiary information and sign the top section of the form.
2. After reviewing the description of the various exemptions below, fill in the circle in the far-left column of the row which applies to the exemption(s) that you are requesting.
3. If you are requesting an exemption as a parent or a caretaker, enter the name and DOB of the person being cared for.
4. If the exemption type requires certification by a licensed medical professional, request that the licensed medical professional complete Section III of the form.
5. You **MUST** return this form to the Department of Health and Human Services either by mail at the address on top of the first page, by fax to 603-271-5623, by submitting the form to your NH EASY account, or bringing the form to your local district office. You may submit to NH EASY or bring to your local district office the exemption form that requires certification by a licensed medical professional **only** if the licensed medical professional has certified that you meet the qualifications for an exemption.

Licensed Medical Professional Instructions:

1. Review the Description of Exemptions below and the exemption(s) that the beneficiary has selected in Section II of the form for accuracy.
2. Enter the certification end-date for the exemption if known.
3. Fill in your provider information and sign the bottom section of the form.
4. If you are submitting this form on behalf of the beneficiary, please send it to the return address on the front page, or fax it to 603-271-5623.

Description of Exemptions

Participation in State Certified Drug Court Program	The beneficiary is participating in a state certified drug court program that has been certified by the administrative office of the superior court. This requires a copy of the legal documentation requiring the beneficiary to participate in the state drug court program.
Parent/Caretaker of Dependent Child Under 6	The beneficiary is a custodial parent or caretaker of a dependent child under 6 years of age. Enter the name and DOB of the child.
Pregnant or Within 60 Days Post-partum	The beneficiary is pregnant or within 60 days post-partum. Enter the due date.
Disability	The beneficiary has a disability as defined in He-W 837.01(h) and is unable to comply with the community engagement requirement due to disability-related reasons. This exemption requires that a licensed medical professional certify the disability.
Caretaker Residing With Immediate Family Member with Disability	The beneficiary resides with an immediate family member who has a disability as defined in He-W 837.01(h) and is unable to meet the community engagement requirement for reasons related to the disability of that family member. This exemption requires that a licensed medical professional certify the family member's disability.

<p>Illness, Incapacity or Treatment Including Inpatient or Residential Outpatient SUD Treatment</p>	<p>The beneficiary is unable to participate in the requirements due to illness, incapacity, or treatment. This exemption includes the beneficiary's participation in inpatient and residential outpatient substance use disorder treatment or in intensive outpatient substance use disorder services that is consistent with ASAM Levels 2.1 and above. This exemption requires a licensed medical professional certify the illness, incapacity or treatment including inpatient or residential outpatient treatment.</p>
<p>Hospitalization</p>	<p>The beneficiary experiences a hospitalization. This exemption requires copies of discharge summaries, or financial or billing information, documenting the hospitalization or dates of stay.</p>
<p>Caretaker Residing With Immediate Family Member Who Experiences Hospitalization or Serious Illness</p>	<p>The beneficiary resides with an immediate family member who experiences a hospitalization or serious illness. This exemption requires copies of discharge summaries, or financial or billing information, documenting the hospitalization or serious illness or dates of stay.</p>
<p>Parent/Caretaker of Developmentally Disabled Child</p>	<p>The beneficiary is a custodial parent or caretaker of a child with developmental disabilities who is residing with the parent or caretaker. This exemption requires that a licensed medical professional certify the child's developmental disability.</p>
<p>Parent/Caretaker of Family Member Requiring Care</p>	<p>The beneficiary is a custodial parent or caretaker who is required to be in the home to care for another relative who resides in the same household due to that individual's illness, incapacity or disability and there is no other household member to provide the care.</p>



Licensed Medical Professional Certification of Medical Frailty Granite Advantage Health Care Program

This certification is to be completed by a licensed medical professional who is qualified to assess the beneficiary for "medical frailty". This certification will be used to support the determination that the beneficiary is medically frail and exempt from the community engagement requirement for the Granite Advantage Health Care Program (Granite Advantage).

The beneficiary **MUST** return this form along with a copy of the BFA Form 320A Beneficiary Authorization for Licensed Medical Professional to Release Protected Health Information to the Department. The forms may be sent to the Department by mail (at the address above), by fax to 603-271-5623, by submitting the forms through NH EASY, or bringing them to a local district office. The forms can be submitted through NH EASY by logging on to <https://nheasy.nh.gov>, accessing the Granite Advantage Community Engagement page and uploading the forms. A beneficiary may submit the forms to NH EASY or bring them to their district office **only** if the licensed medical professional has certified that the beneficiary is medically frail.

"Medically frail" means a beneficiary, as defined in 42 CFR 440.315 (f), with a disabling mental disorder, chronic substance use disorder, serious and complex medical condition, or a physical, intellectual or developmental disability that significantly impairs the ability to perform one or more activities of daily living as certified by a medical professional.

Part I. Beneficiary Information (please print)

Medicaid ID#: _____		
Name:		
Last	First	
Residential Street Address (if homeless write N/A):	City, State, ZIP Code:	
Date of Birth (MM/DD/YYYY):	Gender: M F	Phone #: ()

Part II. Medically Frail Condition

Please check ALL the appropriate boxes in the table that best defines the medically frail condition of the beneficiary:

Definition	Category
Individuals with disabling mental health disorders	<input type="radio"/> Psychotic disorder <input type="radio"/> Schizophrenia <input type="radio"/> Schizoaffective disorder <input type="radio"/> Major depression <input type="radio"/> Bipolar disorder <input type="radio"/> Delusional disorder <input type="radio"/> Obsessive-compulsive disorder <input type="radio"/> Other mental health condition: specify _____

Individuals with substance use disorders	<input type="radio"/> The beneficiary has a diagnosis of substance use disorder consistent with DSM-V* criteria. *DSM-V means the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.
Individuals with serious and complex medical conditions	<input type="radio"/> The individual meets criteria for hospice services, OR <input type="radio"/> The individual has a serious and complex medical condition AND the condition significantly impairs the ability to perform one or more activities of daily living (ADLs).
Individuals with a physical disability	<input type="radio"/> The individual has a physical disability AND the condition significantly impairs the ability to perform one or more activities of daily living (ADLs).
Individuals with an intellectual or developmental disability	<input type="radio"/> The individual has an intellectual disability or a developmental disability as described below AND the condition significantly impairs the ability to perform one or more activities of daily living (ADLs) <ul style="list-style-type: none"> • Intellectual Disability means significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior • Developmental Disability means a disability attributable to an intellectual disability, cerebral palsy, epilepsy, autism, or a specific learning disability (or any other condition of an individual found to be closely related to an intellectual disability as it refers to general intellectual functioning or impairment in adaptive behavior or requires treatment similar to that for persons with an intellectual disability), that is manifested before the age of 22 and that reflects the person's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of a lifelong or extended duration and are individually planned and coordinated.

Part III. Licensed Medical Professional Certification

As a licensed medical professional caring for this beneficiary, I hereby certify that the beneficiary is medically frail based on the beneficiary having one or more of the conditions identified above.

This certification is valid through (MM/DD/YYYY): _____ (May not exceed one year)		
Provider Name (Please print): _____	Date: _____	Contact #: _____ ()
Provider Signature: _____ NPI#: _____		

Please list additional provider notes including any other considerations that should be given to support the "Medical Frailty" of this individual:



Good Cause Request Form Granite Advantage Health Care Program

Use this form to request good cause to excuse the inability to meet the community engagement hours for the one month indicated below. **DETAILED INSTRUCTIONS ARE ENCLOSED.** Print all information in the spaces provided and include 3rd party certification where required.

Name: _____

Last | _____ | First | _____ |

Medicaid ID#: | _____ |

By filling in the circle for good cause and signing this form, I attest under penalty of unsworn falsification pursuant to RSA 641:3 that the information provided to the department in support of this request is true to the best of my knowledge and belief.

Beneficiary Signature _____ Date _____

FOR THE PARTICIPATION MONTH OF (MM/YYYY): | _____ |

	Good Cause Reason	Attestation and Certification	Crediting a Finding of Good Cause
<input type="radio"/>	Birth or death of a family member	Name of family member: Relationship: Date of event:	# of days: _____
<input type="radio"/>	Severe inclement weather	Date(s) of event:	# of days: _____
<input type="radio"/>	Family emergency or life changing event	Description of event: Date(s):	# of days: _____
<input type="radio"/>	Parent/caretaker of child 6-12 unable to secure child care	Self-attestation of inability to secure child care	# of days: _____
<input type="radio"/>	Homeless or unable to find stable housing	Self-attestation	# of days: _____

	Good Cause Reason	Attestation and Certification	Crediting a Finding of Good Cause
<input type="radio"/>	Domestic violence	Court Order OR Self-Attestation	Date range in Court Order: From _____ OR _____ To _____
<input type="radio"/>	Disability	Certification by licensed medical professional.	From _____ OR _____ To _____ If no date range indicated, 100 hours.
<input type="radio"/>	Caretaker Residing with Immediate Family Member with a Disability	Certification by licensed medical professional of family member's disability and duration.	From _____ OR _____ To _____ If no date range indicated, 100 hours.
<input type="radio"/>	Inpatient Hospitalization	Medical documentation	Admitted _____ You will be credited 100 hours.
<input type="radio"/>	Caretaker Residing with Immediate Family Member Who Experiences Hospitalization or Serious Illness	Medical documentation for Family Member's Hospitalization	From _____ OR _____ To _____ # of days: _____
<input type="radio"/>	Other Good Cause	Description:	# of other good cause days: _____

For any Parent or Caretaker good cause above, enter the information for the person being cared for below:

Full Name: _____ Last First
Date of Birth (MM DD YYYY): _____

Licensed Medical Professional Instructions:

1. Review the Descriptions of Good Cause below for "Disability" or "Caretaker Residing with Immediate Family Member with a Disability" that the beneficiary has selected.
2. If, the beneficiary is disabled and unable to meet the community engagement requirement for reasons related to their disability or if the beneficiary's immediate family member identified above is disabled, select the appropriate certification box.
3. Fill in your provider information and sign the bottom section of the form.
4. If you are submitting this form on behalf of the beneficiary, please send it to the return address on the front page or fax it to (603) 271-5623.
5. If you determine that the beneficiary or the beneficiary's immediate family member is *not* disabled, please return this form directly to the department at the address on the front page or fax it to (603) 271-5623.

Descriptions of Good Cause

Birth or Death of a Family Member	For a beneficiary who experiences the birth or death of a family member residing with the beneficiary, a showing of good cause requires self-attestation of the event to include the name of the family member, the date of the event and the family member's relationship to the beneficiary as well as the number of community engagement hours that the beneficiary was unable to complete due to the circumstance at 8 hours per day.
Severe Inclement Weather	For a beneficiary who experiences severe inclement weather including a natural disaster, a showing of good cause requires the date(s) of the event and self-attestation of the number of days the beneficiary was unable to participate due to the circumstance at 8 hours per day.
Family Emergency or Life Changing Event	For a beneficiary who has a family emergency or other life changing event such as divorce, a showing of good cause requires self-attestation of the nature of the family emergency or life changing event to include the number of days that the beneficiary was unable to participate due to the circumstance at 8 hours per day.
Parent/caretaker of Child 6-12 Unable to Secure Child Care	For a beneficiary who is a custodial parent or caretaker of a child 6 to 12 years of age and who is unable to secure child care in order to participate in qualifying community engagement either due to a lack of child care scholarship or the inability to obtain a child care provider due to capacity, distance, or another related factor, a showing of good cause requires monthly self-attestation of the inability to secure child care and the number of hours the beneficiary was unable to complete due to the circumstance at 8 hours per day.
Homeless or Unable to Find Stable Housing	For a beneficiary who is homeless or unable to find stable housing, a showing of good cause requires self-attestation of the number of days the beneficiary was unable to complete due to the circumstance at 8 hours per day.

Domestic Violence	For a beneficiary who is a victim of domestic violence, dating violence, sexual assault or stalking, a showing of good cause requires a copy of the court order which indicates that the beneficiary was the victim of domestic violence, dating violence, sexual assault or stalking OR the beneficiary's self-attestation of domestic violence, dating violence, sexual assault or stalking. Hours will be credited based on the date range specified in the court order at 8 hours per day or based on the beneficiary's self-attestation of the number of days the beneficiary was unable to complete due to the circumstance at 8 hours per day.
Disability	For a beneficiary who has a disability and was unable to meet the requirement for reasons related to that disability but was not exempted from community engagement requirements, a showing of good cause requires self-attestation that the beneficiary was unable to meet the community engagement requirement for reasons related to the disability AND certification by a licensed medical provider of the beneficiary's inability to meet the community engagement requirement for reasons related to the disability. Hours will be credited based on the date range specified by the beneficiary's medical provider at 8 hours per day or if no date range is indicated, 100 hours for one month.
Caretaker Residing with Immediate Family Member with a Disability	For a beneficiary who resides with an immediate family member who has a disability, and was unable to meet the requirement for reasons related to the disability of that family member, but was not exempted from community engagement requirements, a showing of good cause requires attestation by the beneficiary of the number of days the beneficiary was unable to meet the community engagement requirement for reasons related to that disability AND certification by the family member's licensed medical provider specifying the family members disability and the duration, if known. Hours will be credited based on the date range specified by the family member's medical provider at 8 hours per day or if no date range is indicated, 100 hours for one month.
Inpatient Hospitalization	For a beneficiary who experienced inpatient hospitalization but was not exempted from community engagement requirements a showing of good cause requires entering the date admitted to the hospital AND copies of the beneficiary's discharge summaries, or financial or billing information that would substantiate the hospitalization or serious illness. Hours for inpatient hospitalization will be credited at 100 hours for one month.

<p>Caretaker Residing with Immediate Family Member who Experiences Hospitalization or Serious Illness</p>	<p>For a beneficiary who resides with an immediate family member who experienced hospitalization or serious illness, but the beneficiary was not exempted from community engagement requirements, a showing of good cause requires attestation by the beneficiary of the number of days the beneficiary was unable to complete due to the circumstance at 8 hours per day AND copies of the family member's discharge summaries, or financial or billing information that would substantiate the hospitalization or serious illness. Hours will be credited based on the date range specified by the family member's medical provider at 8 hours per day or if no date range is indicated, based on the beneficiary's self-attestation of the number of hours at 8 hours per day.</p>
<p>Other Good Cause</p>	<p>Other good cause requires self-attestation of the circumstances beyond the beneficiary's control which relate to the beneficiary's ability to obtain or retain a qualifying activity to participate in and the number of days the beneficiary was unable to complete at 8 hours per day. This includes illness and outpatient hospitalization.</p>